AN ADDRESS BY

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

OF THE

HEALTH CARE FINANCING ADMINISTRATION

U. S. DEPARTMENT OF

HEALTH & HUMAN SERVICES

OCTOBER 29, 1987

SAN FRANCISCO, CALIFORNIA

The purpose of this national invitational conference is "Assessing Competition in Health Care." In such an effort, it is useful to look ahead and to look back. Given the recent precipitous decline on Wall Street, and fervent study of our economic situation, I believe that an article by former Commerce Secretary Peter Peterson, in the October, 1987, issue of The Atlantic Monthly, will get a lot of well-deserved attention.

Peterson points to the long-term problems in our economy, and calls for the nation to face its problems directly and to do so soon. Among the issues he discusses is the need to deal with the continued high rate of health

care spending growth. Peterson says that America has let its infrastructure crumble, its foreign markets decline, its productivity dwindle, its savings evaporate and its budget and borrowing burgeon. He says that the day of reckoning is at hand, in his article entitled "The Morning After." His prescription for slowing health care spending is replacing the "horrendous, indeed perverse inefficiencies" of the current system with the discipline of market forces.

I agree with this push for increased reliance on market forces -- indeed that is the topic that brings us together today. It is easy to become depressed

reading Peterson's article -- especially his forecast of the impact our behavior may well have on our children and grandchildren.

His words are a call to action -- and after the recent gyrations of the stock market, we may get some. But the important question is "what kind of action would be best?".

I believe we can learn from the 62nd Essay of the Federalist Papers, where James Madison wrote:

> It will be of little avail to the people that the laws are made by men of their own choice if the laws are so voluminous that they cannot be read, or so incoherent that they cannot be understood; if they be repealed or revised before they are promulgated, or undergo such incessant changes that no man, who knows what the law is today, can guess what it will be tomorrow."

Perhaps Madison had premonitions of Medicare when he wrote that. As we move to address the huge financial and economic problems noted by Peterson, let us not forget Madison's warning of 200

years ago. With consistency and coherency as our watchwords, a major choice we continue to face in health care is whether to centralize or decentralize decision-making and authority in the system. Centralization has its many merits, but is limited in its ability to accommodate to local differences. It is effective, however, in establishing the goals and standards that will make a decentralized "Federal" system for health care benefits not only plausible but desirable.

The Reagan Administration has made a major push for more competition (including market forces and appropriate

incentives) in health care. We have made noteworthy progress in this effort. I will focus primarily on the Medicare program in my remarks today.

It is important to note that under President Reagan spending for Medicare has increased more rapidly (in percentage terms) than has defense spending. This is true, despite the much ballyhooed "cuts" in Medicare and the "dramatic growth" in defense. So we continue to have much work to do.

Much change has occurred in health care in the past few years -- it is often described as a "revolution." Clearly there has been a move toward competition in health care. The most directly market-oriented Medicare reforms, I believe, are:

- Allowing Medicare beneficiaries the option to enroll in private health plans such as HMOs and other competitive medical plans, and

- Establishing the Participating Physician program, which gives beneficiaries the ability simply to choose doctors who accept assignments all the time, and permits physicians to choose whether to be a part of this program.

These two important program changes were passed in 1982 and 1984 respectively. Of course, in 1983 another major part of this revolution

was passed by the Congress, the Prospective Payment System for hospitals in Medicare. It has had far and away, the greatest effect on the health care system. It has given hospitals important incentives to deliver health services efficiently -- and it is a dramatic improvement over the old cost-reimbursement system for hospitals.

But PPS is a centrally administered national price payment system, not price competition. The only "competition" among hospitals in PPS is non-price -- in a continuing effort to maintain or increase patient volume.

One of the things we have focused on more recently in HCFA is the evidence we have for the continuing increase in cost per case under PPS. Despite strong incentives for holding costs down, they continue to rise.

On the one hand, this finding may lead one to conclude that we have not applied sufficiently firm pressure (not "squeezed hard enough") in order to give hospitals needed incentives to control costs.

Or, alternatively, we may have given hospitals a difficult if not an impossible task. It is open to question whether hospitals really can control

their costs further. I believe a central point at issue is the degree to which hospitals truly can control physician decisions since, after all it is predominantly the decisions of doctors that drive health spending.

We have a Medicare program that is largely based on the services of non-profit hospitals. We are told that "profits" that such hospitals accrue under PPS go mostly to enhanced "quality" and "amenities." However, because PPS is a closed system -- that is, we never explicitly take money out of the hospital system -- we do not know to what extent hospitals really could

safely economize further. This is one of the major limitations of the prospective payment system and is further complicated by Congress using the PPS update to accomplish major budget savings.

Reducing the over-supply of hospital beds is one alternative. Given the low and still declining hospital occupancy rates in many parts of the country, one of the major things that could help hold down Medicare hospital spending is the political will to allow some hospitals to go out of business. I believe it is implausible to put great reliance on such political will -- especially given our current experience with the rural hospital sector.

As PPS has pinched more tightly in rural America, the Congress has responded with special rural rules and higher rural payment updates. Some of the changes were well-warranted (and even advocated by HCFA as sound policy). However, other changes -- contemplated or proposed -- fly in the face of knowledgable observers who recognize that some rural hospitals need to change or even close. Unfortunately, as time goes on, we are seeing the process becoming even more politicized to the point where local issues are given greater emphasis than overall national policy.

This is particularly problematic under PPS, since we only have national tools with which to deal with varying local markets. Adornment of a national program with local "fixes" underscores fundamental problems with such a nationally administered price system. Consequently, we are beginning to have real doubts about further progress in restraining hospital spending under Medicare using PPS alone. To be clear, it is <u>far</u> superior to cost-reimbursement, but it has its own faults. not the least of which is its impotence in the face of excessive utilization by physicians.

Part A (largely hospital) expenditure growth is not our only problem. Part B (largely physician) spending is out of control. In September, we announced that the Part B premium will rise 38.5 percent come January 1, 1987.

This change is brought about by many factors, but chief among them is rapidly growing Part B outlays. At a September 30 Ways and Means Committee hearing on this subject, I discussed the problem at length, emphasizing that it is not just a unit price phenomenon, but is especially driven by burgeoning utilization of Part B services.

We know that much of the increase in utilization is good and to be applauded -- it is doctors doing good for their patients. But we also know that some of this increase is unnecessary. A growing body of literature questions the need for many services.

I believe we, especially now, need to question what has been a fundamental premise of the American health care system: "More is better." More is not necessarily better.

We need seriously to examine practice patterns and to reach consensus about appropriate patterns. Until

recently the burden of proof in this debate has been on those who sought to have doctors (and others) provide less, in order to ensure that quality did not suffer.

As we look for ways to constrain Part B spending growth, using incentive payment systems like PPS for doctors will be difficult. This is because provider volumes are much smaller for doctors than for hospitals and there is greater heterogeneity across providers due to specialization. These both lead to quite significant pricing problems. Also, since utilization growth is the major component of outlay growth, price-only mechanisms like RVS fee schedules are not sufficient.

The best cost-control mechanism for physician services is a competitive system that shifts patients (through their own choosing) from one provider to another. In exchange for increased patient volume, the physician agrees to pay a "price," that is, to submit to some tighter restraint. The current Medicare participating physician program is a prime example of such a mechanism. Here doctors receive enhanced volume and forego balance billing in their fees.

In economic terms, that is how one exploits excess capacity -- not with an administered price system, but by creating useful competition amongst providers.

By any reasonable measure we now do have a glut of providers, both of doctors and of hospitals. It is a buyers market and the Federal government should take advantage of it.

As I said earlier, quality measurement is an essential part of such a strategy -- because we must ensure that we are shifting patients to the good providers. This is why the medical community needs to determine, within a range, what is appropriate practice.

In this third decade of Medicare, we are focusing our attention and resources on defining, quantifying, measuring and ensuring quality in our programs. This quality initiative has many facets, one of which is our upcoming publication of selected hospital mortality information.

The prime idea behind this information release is to stimulate further work on methods for quality measurement. Such measures are needed as we question the "more is better" premise. Quality measurement will remain a high priority on HCFA's agenda on into the future. Furthermore, we are working to move from focusing solely on hospital quality, to including that of doctors. Our release of hospital mortality information is one step along a longer but essential road that I am convinced will lead us to be much better able to define and ensure quality in health care.

Our near-term strategy for constraining Part B outlays likely will include price restraint, with limitation of the prevailing charge increase for non-primary care practitioners. In addition, we will look to more intensive case-by-case utilization review to determine the necessity and the appropriateness of services.

We are also developing a possible Medicare physician payment reform proposal that embodies a broader set of competitive principles -- a preferred provider organization within the Medicare program. We look at this alternative, not as an abstract idea, but as a practical present reality in the private sector. We seek to take advantage of it in the Medicare program.

We would select a sub-set of doctors -- the careful practitioners of quality medicine -- and then steer a volume of patients to them using economic incentives, such as lower beneficiary copayments. This is the basic concept of a Medicare PPO, but we are working on the important details.

Just as the participating physician program has caused competition among physicians (with a favorable impact on beneficiaries) -- so would this PPO -- only more so.

We would look to contract with private organizations and build on the experience of the private sector in competition. I believe this offers real hope for restraint in the increase in Part B outlays.

But, having told you about the problems we have in Medicare Part A and Part B, let me say clearly: There is a better way of dealing with these problems -- the Private Health Plan Option under Medicare.

Please remember the quote from James Madison. Under our uniquely American system of separation of powers with

checks and balances, I believe it is much better to rely on a decentralized system and private health plans in Medicare.

Under the TEFRA authority, much has been accomplished with HMOs and CMPs in Medicare. We have provided senior citizens with a choice. We now have Medicare risk contracts available as a choice for more than one-half of our 31 million beneficiaries.

And about one million have so chosen -- to enroll in one of 158 plans in 34 states. You are quite aware of the advantages of such plans to our beneficiaries -- more benefits, lower

copayments, less paperwork. But we believe that as the elderly become increasingly familiar with managed care arrangements, this number will grow even more rapidly.

It is important for me to point out, though, that HMOs will need to prove themselves, not in competition with a fat and sassy traditional Medicare program, but one that is lean, mean and efficient. Also, Medicare is improving -- witness the upcoming catastrophic coverage.

We are engaged in a "market test" of the Private Health Plan Option in Medicare. It is up to us in HHS to prove whether we can operate the program

in a fair and beneficial manner -- fair to the plans with whom we do business, so that these plans grow; and beneficial to the consumers served, so that they sell the concept to others.

We are aware that about 25 of the current Medicare HMOs/CMPs will not renew their contracts with us for next year. However, the vast majority among this number have no or a small enrollment. In aggregate, these plans represent 4 to 6 percent of our PHPO enrollment -- this is a comparable percentage to our experience with cancelled contracts in 1986. More to the point, other plans <u>are</u> signing up for new risk contracts.

In all of this, we seek for plans to make whatever business decisions are right for them. But we also seek to operate this program so that it does have a fair market test.

To that end, we recently announced an average 13.5 percent increase in HMO/CMP rates for 1988. But there are perceived "flaws" in our pricing mechanism, the AAPCC. We are currently engaged in activities designed to improve our payment system. We are planning to ask all the TEFRA risk plans if they would be interested in a demonstration of new AAPCC refinement mechanism.

These demonstrations will focus on the Diagnostic Cost Group method of pricing. This was recommended by a task force headed by Joe Newhouse of Rand which looked at the AAPCC. On the task force were members from the industry, actuaries, researchers and others.

The Diagnostic Cost Group method combines the current demographic information with diagnostic information to give a better prediction of enrollees' future need for health care services.

HCFA's Office of Research and Demonstrations is working to start pilot projects in late spring of 1988 to work out administrative details -- with full demonstrations in progress by October.

We also seek to launch a series of demonstrations of another type of capitated plan -- based on pre-formed groups of Medicare beneficiaries. The retired enrollees in an employer or union operated health plan would participate in a Medicare Insured Group demonstration. We recently signed an agreement with the Amalgamated Life Insurance Company to develop such a demonstration.

We are also looking carefully at changing the geographic component basis of our rate payment. Currently, we make AAPCC payments based on counties. Counties often do not represent a homogenous health cost area. We may well look at batching zip codes based on the homogeneity of their health costs.

There are some (particularly in the Congress) who are skeptical about our demonstration ideas or about certain physician incentive payment arrangements. But remember that we face a problem -- continuously growing Medicare outlays. As Peter Peterson said -- we need to work together for solutions. And it is not enough to just find potential faults in various possible solutions.

For my part -- long term solutions need to focus on decentralization, competitive forces, and incentives for the appropriate use of medical services. I believe this offers the best hope for the future. Of course, a more competitive health care

system raises yet other issues for debate; indeed witness this conference itself. But I will leave that discussion for another time.

We must resist telling ourselves that the old ways were the best ways, and commit ourselves to the enterprise ahead.

We believe our policy is one of vision, but a vision tempered by pragmatism. We believe that a more competitive, decentralized system of private providers and aware consumers will ensure a bright future for health care in America, at a price we all can afford.